The article by Askanazi and co-workers addressed the efficacy of postoperative parenteral nutrition.[1] This small, randomized trial of 35 patients undergoing total cystectomy was intended to determine changes in physiologic parameters. In retrospect, the authors noted a shorter length of hospital stay in patients receiving treatment but conceded that this was not due to differences in complications or mortality. Many studies have reported that giving parenteral nutrition changes physiologic parameters. Unfortunately, these observations have not translated easily into substantial improvement in outcomes. Until more definitive studies are completed, such as the Veterans Administration cooperative study on perioperative parenteral nutrition,[2] we should adopt a prudent approach to this therapy.

STEVEN KATZ, MD
Robert Wood Johnson Clinical Scholars Program
University of Washington
Varsity Apartments, HQ-18
3747 15th Avenue NE
Seattle, WA 98105

ROBERT K. OYE, MD
Department of Medicine
UCLA School of Medicine
Los Angeles, CA 90024

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Disability and the SSA

To THE EDITOR: It is not uncommon for a treating physician to think that a patient who has been denied Social Security disability benefits truly is disabled. This difference of opinion might be avoided if the treating physician understands how Social Security disability is determined and also understands the importance of documenting the limitations of function imposed by the medical impairment.

Physicians are accustomed to gathering the historical information and results of examination and corroborative laboratory evidence to establish a working diagnosis and treatment program. They are not accustomed to documenting in the medical record the limitation of function that impairment imposes, however.

According to the Social Security Administration (SSA), disability exists when a documented physical or mental impairment would prevent the claimant from performing all types of work for at least 12 months or when the disability could be expected to result in death. The treating physician routinely is requested to furnish medical records or reports to the state agency responsible for processing Social Security disability claims. A quick and thorough response results in the best decision. Once the medical evidence is received, a medical consultant evaluates it and determines whether the claimant's impairment meets or equals "The Listing of Impairments," a booklet containing over 100 medical conditions that the SSA considers disabling. Statutory blindness, brain cancer, and mental retardation with an IQ below 60 are examples. In such cases, both the treating physician and SSA would agree a claimant is disabled.

When an impairment of listing-level severity is not documented, the medical consultant then evaluates what the claimant can do despite the limitations imposed by his or her impairments. This assessment is referred to as the residual functional capacity (RFC) and is expressed in terms of amounts of standing, walking, sitting, lifting, and other work-related abilities the claimant retains. At this point, a disability analyst determines whether the RFC would permit past work. If not, the claimant's age, education, and work experiences are evaluated in relation to the RFC to determine if the claimant can do other kinds of work. Many treating physicians are unaware that two claimants with identical medical conditions could receive opposite disability decisions because of differences in age, education, and vocational background.

The most accurate determination of disability occurs when the treating physician not only provides complete and detailed objective medical evidence regarding a medical condition but also describes the restrictions in function imposed by the impairment, such as in lifting, bending, reaching, walking, standing, sitting, manipulating, hearing, seeing, thinking, and remembering. This medical assessment by the treating physician of the limitations of function is used by the medical consultant for assessing the RFC.

Sometimes the medical consultant or disability analyst telephones the treating physician to discuss the patient's limitations of function, response to treatment, and prognosis, especially when there is pain or weakness due to a medically determined condition documented by objective evidence and it is necessary to determine the extent to which these symptoms limit function. For example, weakness in a person testing positive for the human immunodeficiency virus and having a marked reduction in T4 helper cells, fever, and other symptoms or pain in a person with lumbar disc disease documented by magnetic resonance imaging could limit function.

A treating physician who wishes to aid a patient in a disability claim should be aware of the need to furnish a detailed description that the impairment imposes on function, along with thorough objective evidence that supports the opinion. When this is done, both the patient and society will benefit from the correct decision being made.

R. WAYNE MALL, MD
Medical Consultant I, Quality Assurance
Disability Evaluation Division
California Department of Social Services
PO Box 24225
Oakland, CA 94623

Continuing Stress and Hypertension

To THE EDITOR: Dr Mustacchi has accomplished, in the August issue, a most comprehensive literature review on the subject "Stress and Hypertension."[1] His conclusions, however, were startling and did not match the material gathered in his excellent review. His statement, "It is still unclear if repetitive or continuing stress will induce fixed hypertension," certainly is not justified after a review of the medical literature. His speculation that these "repetitive exposures to stress can result in habituation" is contrary to the literature that he himself reviewed and contrary to clinical impressions that I believe every physician has experienced. I do not believe that a person can get used to a continuum of stress. Indeed, the psychophysiologic responses to stress continue and, if anything, stressed persons react more adversely to stress. Dr Mustacchi's own literature review has shown substantial epidemiologic evidence of hypertension and complications of hypertension, such as strokes in an occupational setting that characteristically has a high stress level. A recent article in *JAMA* showed that persons working with "high job strain" had a substantial increase in the left ventricular mass index as measured echocardio-

graphically. I think there is little doubt that continued, unusual, prolonged emotional stress causes, aggravates, and accelerates hypertension and will lead to left ventricular hypertrophy and complications of hypertension, which will lead to strokes. I think that unremitting stress must be accepted as a risk factor in hypertension and its complications. Dr Mustacchi states, "Plausible hypotheses linking stress to hypertension have been advanced, but the longitudinal information required for a satisfactory validation is not yet available." When does he expect that information will be available? I hold that the evidence is overwhelming. I hold that some persons, however learned as the author, will never be convinced.

It is extremely important that *The Western Journal of Medicine* acknowledge that Dr Mustacchi's reluctance to accept this information as being definite is not shared by any other physicians who regularly encounter this problem.

ALVIN MARKOVITZ, MD
Associate Clinical Professor of Medicine
University of Southern California School of Medicine
11600 Wilshire Blvd, Suite 512
Los Angeles, CA 90025

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Dr Mustacchi Responds

To THE EDITOR: I wish to thank Dr Markovitz for his appreciative words about my recent review on "Stress and Hypertension."[1] There seem to be, however, two areas in which his beliefs differ from the conclusions of my review. Both deal with occupational stress.

He considers speculative and unjustified the inference that "repetitive exposures to stress can result in habituation."[1] Habituation is a conclusion well supported by the reviewed studies of naval aviators,[2] bus drivers,[3] surgeons and operating room personnel,[4] white and blue collar workers,[5] and air traffic controllers.[6,7]

I consider the epidemiologic evidence I supplied to be both sound and persuasive, although Dr Markovitz seemingly does not find it so. Because he did not reference the studies that prompt his beliefs, I am unable to explain or reconcile these differences.

He also disagrees with my conclusion that "plausible hypotheses linking stress to hypertension have been advanced, but the longitudinal information required for a satisfactory validation is not yet available." He claims that such evidence is "overwhelming" but does not provide the reader with any reference substantiating that assertion. I should point out that when I started searching the literature, I shared his opinion, and I expected to find ample documentation in support of this clinical belief. Not only did my search prove sterile, but, when critically analyzed from the epidemiologic viewpoint of causality, several studies indicated that, if anything, the evidence was on the other side.[3,6,8]

If I have inadvertently overlooked pertinent longitudinal studies known to my colleague, I would be grateful if he would share them with me. He quotes the *JAMA* article, "The Relationship Between 'Job Strain,' Workplace, Diastolic Blood Pressure, and Left Ventricular Mass Index," also quoted by me. This is a cross-sectional study, not a longitudinal one, and when causality is at issue, longitudinal studies are essential. Additional legitimate questions arise about the uncertain significance of a relationship between left ventricular mass and job stress found only in workers aged 30 to 40 but not in those aged 41 to 60.

Some cross-sectional studies render very attractive the conjecture that the transient blood pressure elevations caused by stress lead to sustained hypertension but, as already intimated by Dustan,[10] this hypothesis is still not epidemiologically validated.

Some serious misperception seems to have crept into the last paragraph of the letter when it alludes to my "reluctance to accept this information as being definite." I do not know how this inference was reached. All I can say is that my review brings together the indefinite nature of stress and the definite information contained in the more than 100 reviewed articles. Concern with definitions structures much of epidemiologic thinking, and it is exactly because I considered definite the published information that I sought to define its limits both in extent and character as well as within the framework of the criteria of causality.

PIERO MUSTACCHI, MD
Clinical Professor of Medicine and of Epidemiology
University of California, San Francisco, School of Medicine
San Francisco, CA 94143-0560

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The Peril of Espresso Machines

To THE EDITOR: We read with great interest the letter from Dr Shusterman in the June issue regarding "espresso maker's wrist."[1] We describe another complication of using this machine. A 34-year-old, otherwise healthy man operates a coffee house adjacent to our medical center. One morning while savoring a cappuccino, we noted that he was massaging his right hypothenar eminence with his left hand. Upon inquiry, he complained of dysesthetic pain on the medial aspects of both palms and paresthesias in the ulnar-innervated digits bilaterally, particularly after operating the hand crank of the espresso maker. He was making approximately 100 espresso drinks a day, with each drink requiring four or five movements of the crank arm. On examination, he had normal motor bulk and strength of the upper extremities, with sensory examination revealing diminished light touch and pinprick in the fourth and fifth digits bilaterally. In addition, a positive percussion test over the ulnar nerves at both elbows was noted. Electrical studies showed substantial reduction of motor conduction velocity across